DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-08

2. STATE: NV

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42CFR413 and 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ None
b. FFY 2003 $ None

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19D, pages 1 through 16

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D, pages 1, 1a, 1b, 1c, 2, 2a,3,4,5,6,6a,6b,6c,7,8,9

10. SUBJECT OF AMENDMENT: Revise rate setting methodologies for nursing facilities and to provide flexibility to the State in granting rate increases rather than at specified dates or intervals.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Michael J. Willden

14. TITLE:
Director, DHR

15. DATE SUBMITTED:
May 23, 2002

16. RETURN TO:
John A. Liveratti, Chief
Compliance Nevada Medicaid
1100 East William, Suite 102
Carson City, Nevada 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 26, 2002

18. DATE APPROVED:
June 23, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE:
Associate Regional Administrator
Division of Medicaid

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

PAYMENT FOR LONG TERM NURSING FACILITY SERVICES METHODS AND STANDARDS

Payment is made for services provided in nursing facilities, including nursing facilities for the mentally retarded, in accordance with Section 1902(a) (13) of the Social Security Act as amended.

A. Hospital-Based Facilities: (Hospital-based facility is defined as: a) a facility sharing a common building or common tract of land with a hospital owned or operated by the state, or an instrumentality or unit of government within the state, located within a county of a population of 100,000 or less; or b) a facility (public or private) which prior to July 1, 1992, was paid for both inpatient hospital services under Attachment 4.19-A of the Medicaid State Plan and long-term nursing facility services under this section.)

1. Hospital-based nursing facility services are paid for under Medicare reasonable cost-based reimbursement principles, including the routine cost limitation (RCL), and the lesser of cost or charges (LCC).

   Effective October 1, 2001, hospital-based nursing facilities shall continue to be reimbursed under Medicare's cost based reimbursement principles, along with the other provisions of paragraphs A.2 and A.3.

   Under this methodology, payment will follow any and all applicable Medicare upper payment limitation (UPL) requirements such that payments will not exceed the UPL. The rates the State of Nevada would pay per day of nursing facility care comply with the Medicare upper payment limit at 42 CFR 447.272, as amended.

   The routine cost limit (RCL) used in cost settlements will be $160.14 per day, effective October 1, 2001. This RCL will apply to cost reports ending on or after October 1, 2001, and will only apply to the portion of the cost report period on or after October 1, 2001. For those cost reports beginning prior to October 1, 2001 and ending on or after October 1, 2001, a weighted average RCL will be used. The RCL applicable to the portion of the cost report period prior to October 1, 2001 will be the per diem routine service cost paid to the facility during the most current cost report period ending prior to October 1, 2001. The RCL applicable to the portion of the cost report period on or after October 1, 2001, will be the RCL of $160.14, as adjusted for inflation. For example: If a hospital-based facility with a June 30 year end was paid $140 per day for routine service cost during its year ending June 30, 2001, the $140 per day would be the RCL for this facility during the portion of the cost reporting year from July 1, 2001 through September 30, 2001. The RCL for the remainder of the year ending June 30, 2002 (October 1, 2001 through June 30, 2002) would be the $160.14 RCL, as adjusted for inflation.

   The $160.14 RCL will be indexed (adjusted for inflation) from October 1, 2001 to the midpoint of the cost-reporting period to which it is applied. The nursing home without capital market basket index as published by DRI will be used in indexing the RCL. If this index ceases to be published, a comparable index will be used.

   The Medicaid program will re-base the RCL every other year, beginning July 1, 2003, using audited hospital-based nursing facility cost report data, input from the hospital-based nursing facility providers, and other information deemed appropriate.

2. In no case may payment for hospital-based nursing facility services exceed the provider's customary charges to the general public for these services.

3. Each facility will receive interim payments of the lower of 1) billed charges; or 2) an interim payment percentage that is the ratio of costs to charges from the facility's most recently audited cost report.

B. Free-standing Nursing Facilities (Free-standing nursing facility is defined as any other facility providing nursing facility services, except hospital-based nursing facilities.):

1. Reimbursement Methodology – January 1, 2002 through June 30, 2002:

a. In preparing the free-standing nursing facilities for a resource utilization group (RUG) based Medicaid reimbursement system, a transitional rate setting process will be adopted effective January 1, 2002. The significant elements of this system include the following:

b. Base operating rates will be calculated for each facility effective January 1, 2002. The base operating rates will be calculated for each free-standing nursing facility using the weighted average operating rate for each facility effective October 1, 2001, (excluding SNL-3 days and rates). The days used to prepare the weighted average operating rates will be paid nursing facility days from January 1, 2001 through June 30, 2001 (excluding SNL-3 days) as shown on a paid claims listing prepared in November 2001. Each facility's capital rate effective October 1, 2001, will be added to their weighted average operating rate. If the statewide Medicaid day weighted average operating and capital rates, calculated as described above, exceed the budget target rate of $121.02, a budget adjustment factor will be employed to adjust the calculated rates to meet the budget target.

c. For those facilities with unstable occupancy (i.e. facilities receiving their initial Medicaid certification on or after January 1, 2000), their base rate will be adjusted for changes in Medicaid acuity as follows:

1. A snapshot Medicaid average case mix index (CMI) will be calculated for each facility effective October 1, 2001.

2. Medicaid average CMIs will be prepared for these facilities as of January 1, 2002 and April 1, 2002, using the same weights as were used to prepare the October 1, 2001 snapshot.

3. The change in average Medicaid CMI, for each unstable occupancy nursing facility as measured from October 1, 2001 to January 1, 2002, and from October 1, 2001 to April 1, 2002, will be used to proportionally increase or decrease 40% of that facility's operating rate effective January 1, 2002 and April 1, 2002.

2. Reimbursement Methodology July 1, 2002 through June 30, 2003:

a. Effective July 1, 2002, each nursing facility's base rate (the rate in effect for each facility on June 30, 2002) will be adjusted for the change in their average Medicaid CMI. The ratio to use in this calculation will be developed using as its numerator each facility's simple average of their Medicaid CMI as of January 1, 2002 and April 1, 2002. The denominator will be the simple average of each facility's Medicaid CMI calculated as of October 1, 2001 and January 1, 2002.

b. The rates in 2.a. will be further acuity-adjusted quarterly. In preparing these rate adjustments, the denominator of the fraction described in item 2.a. above will remain unchanged for each facility. The numerator of the fraction for October 1, 2002 adjustment will reflect the simple average of each facility's Medicaid CMI as of April 1, 2002 and July 1, 2002. The July 2002 and October 2002 average Medicaid CMI will be used in the January 1, 2003 rate setting, while the October 2002 and January 2003 average Medicaid CMI will be used in the April 1, 2003 rate adjustments.

c. The acuity-adjusted rates, as described above in item 2.a. and b., will be further adjusted by an adjustment factor to not exceed the industry Medicaid weighted average per patient day rate effective January 1, 2002 as described in B. 1. b. above.

d. 40% of each facility's weighted average operating rate will be subject to the acuity adjustments described in this section.

e. Facilities that were initially certified between July 1, 1999 and December 31, 1999, will have their rates adjusted to reflect the adjustments to rates that were made to unstable occupancy facilities during the period of January 1, 2002 through June 30, 2002. These rate adjustments will be effective July 1, 2002. The intent of this provision is to treat facilities initially certified during this period as if they had been identified as unstable occupancy facilities during the period from January 1, 2002 through June 30, 2002.

RESERVED FOR FUTURE USE